PATIENT SAFETY

FEEDBACK

Patient Safety Reporting System
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FEEDBACK shares excerpts of reports sent by VA employees to PSRS. Actual quotes appear in *italics*. Created by an agreement between NASA and the VA in May 2000, PSRS is a voluntary, confidential and non-punitive reporting system. PSRS encourages VA employees to describe safety issues from their firsthand experience and to contribute their information to PSRS.

The theme of this issue is drawn from PSRS reports concerning safety situations related to communication and documentation. These reports represent significant input to PSRS and underscore the critical role of verbal dialogue and written messages to ensuring quality and safe health care. JCAHO has recently stated that lack of communication is now the top root cause of sentinel events. Some JCAHO safety goals for 2003 are related to taking steps to improve communication and documentation.

Connect the Docs

A physician reporter described a miscommunication between anesthesiologists and a vascular surgeon during a carotid endarterectomy.

- *During fairly long dissection and exposure of carotid artery, the attending surgeon requested what I (attending anesthesiologist) heard distinctly as "two thousand of heparin."*

The dose was given. The resulting ACT (activated clotting time) was 201. Later, an additional 1500 units of heparin were given. The second ACT was below 200.

- *The attending surgeon asked, 'Why do you think the ACT is so low?' We commented that it wasn't that surprising given the relatively low dose of heparin. The surgeon insisted that* [the order was] *"ten thousand." ... Additional heparin was administered to bring the ACT over 300.*

The surgery proceeded uneventfully, and the patient made a full recovery. The reporter had suggestions for preventing similar future miscommunications:

- *It is not our usual practice to do a "readback" of these doses, nor to verbalize them using a digit-by-digit technique (such as "one zero thousand"). These practices should be incorporated for critical issues such as the dose of important drugs.*
- *In cardiac surgery, the heparin is drawn up by a nurse…The dose is also written on a "grease board" in the OR... if the surgeon filled in the planned dose of heparin on the grease board, ... everyone would know the desired dose.*

Cracks in "No Egg" Diet

Thirty thousand emergency department visits and between 150 and 200 deaths per year are caused by food allergy reactions. (The Food Allergy & Analphylaxis Network, 2002) A PSRS reporter detailed a situation of food allergy to eggs:

- [The patient's] *throat constricts until he can not breathe if he consumes eggs. This allergy was entered into the electronic adverse reactions file of the patient's computerized medical record (CPRS).*

Despite that entry into CPRS:

- *The next morning the clinical dietitian assigned to that ward was alerted by the patient's nurse that the patient, with allergy to eggs clearly stated on his tray ticket, received french toast (which is made with eggs) for breakfast.*
- *The dietitian responded by also entering "no eggs" as a food preference into the dietetics electronic file because the CPRS/VISTA adverse reactions/allergy reaction file is not linked to... the dietetics electronic food preferences file... Unfortunately, nursing staff do not have access to enter patient food preferences into the dietetics package.*

Even this further intervention did not prevent a second close call:

- *... with the allergy to eggs electronically printed on the patient's tray ticket, he received macaroni salad for lunch, which contains hard-cooked eggs. An observant nurse removed the salad from the patient's tray… he stated he would not have eaten it anyway, for fear of eggs in the recipe.*

The combination of alert employees and a cautious patient prevented potential allergic reaction.

Painful Transcription

By double-checking a new narcotic order, a nurse reporter found a discrepancy between the dose ordered by the physician and the dose transcribed by a colleague.

- *Two shifts previous to mine,* [the nurse] *initiated narcotic documentation with incorrect dosage (not enough) to be given, resulting in inadequate pain control.*

The difference in medication administered over two shifts was significant:

- *Med/Dose ordered: Morphine Sulfate 20 mg solution per G* [gastric] *tube every 4 hours. Med/Dose delivered: Morphine Sulfate 10 mg solution per G tube every 4 hours.*

A month later, changes were made to prevent similar future problems. Instead of medication orders being transcribed by hand onto the patient medication administration record at the bedside, a hard copy printout of the orders is placed in the medication administration record.

Right Patient, Left Hernia

Surgery on the wrong patient was prevented by careful attention to documentation during a preoperative planning conference.

- [We were] *using the documents from the surgical outpatient office. At the same time, the schedule of operations (from the VA surgical package) was reviewed for correctness. There was a discrepancy between the two documents.*

The documents listed different patients, who had the same identifiers. (Interestingly, both had hernias.) The team corrected the discrepancy immediately.

The physician reporter said the problem is that all patients are identified in the computer only by the first letter of last name and the last four digits of their social security number. The reporter suggested that, when duplicate identifiers exist, a warning should come up on the computer screen and require verification.

Tale of Two Labels

Double-checking all labels on an IV bag prevented a medication error:

- *When getting ready to give patient's IV medication Metronidazole 500 mg in NS* [Normal Saline], *I noted that the Metronidazole label was on a package labeled Cefazolin... Medication was not given.*

The reporter then checked the rest of the medications for that patient.

- *In fact, 3 Cefazolin bags were labeled with Metronidazole for this patient... I contacted Pharmacy for the correct medication.*

Alarming Announcements

A recently-installed alarm system poses a safety challenge, as described by a reporter. The new equipment identifies buildings in an unfamiliar way.

- *This alarm sounds with a female voice indicating what the event is and where it is located using a numeric code. For example, the alarm when sounded may say, "code 700 building 85." Most of the staff is used to identifying the building location with a letter.*
- *So when the code is sounded the actual location of the event is usually unknown.*

The reporter finds it difficult to make the transition.

- *Right now I am sitting in the — wing and really don't know what this wing's number is...*

The reporter brought this situation to the attention of responsible staff, but...

- *I have yet to see a number posted inside the facility indicating what number is assigned to what building.*

PSRS Report Forms are available at VA Facilities and at the PSRS Website http://psrs.arc.nasa.gov

You can get your own copy of FEEDBACK mailed to you: On the PSRS Website click "Contact Us." Or mail your request to PSRS, PO Box 4, Moffett Field, CA 94035-0004.

When in Doubt, Fill it Out... When in Doubt, Fill it Out... When in Doubt, Fill it Out...

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